The US perspective: lessons learned from the Racial and Ethnic Approaches to Community Health (REACH) Program

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Introduction

In 2002, the US Institute of Medicine (IOM) reached the conclusion 'Disparities in health care are one of the nation's most serious health care problems. Research has extensively documented the pervasiveness of racial and ethnic disparities.'[1]

The disparities noted by the IOM are widespread. In the US, deaths from heart disease are 30% higher among African-Americans than Caucasians, and deaths from stroke are 40% higher among African-Americans than Caucasians. The incidence of diabetes is 2.3 times higher among American-Indian Alaska Natives, 1.6 times higher among African-Americans, and 1.5 times higher among Hispanics when compared with Caucasians. The rate of cervical cancer is five times higher in Vietnamese women than Caucasian women. Finally, the rate of infant mortality (death within the first 12 months of age) is 2.5 times higher in African-Americans than in Caucasians.

While these statistics may seem disturbing, the fact that these disparities are not new is even more disturbing. In fact, WEB Dubois documented alarming disparities between African-Americans and Caucasians in 1899 when he wrote *The Philadelphia Negro*. Dubois noted alarmingly high rates of cancer, heart disease and stroke among African-Americans residing in Philadelphia. In 1899, Dubois called for the elimination of health disparities with the statement: 'We must endeavor to eliminate, so far as possible, the problem elements which make a difference in health among people'.[2]

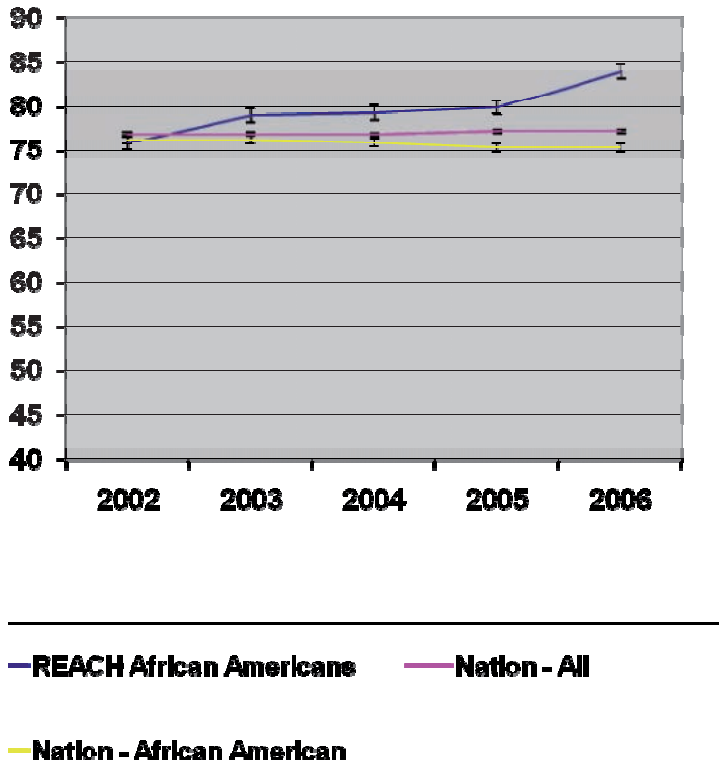
In 1999, the US Federal Government launched the REACH (Racial and Ethnic Approaches to Community Health) Program.[3] This program, while headed by the Centers for Disease Control and Prevention (CDC), had a number of federal and private sector partners who were instrumental in guiding it. These partners included the Offices of Minority Health, Public Health Science, and the Assistance Secretary for Program Planning and Evaluation from the Department of Health and Human Services. Other partners included the Office of Minority Health and Health Disparities at the National Institutes of Health, the Administration on Aging, the California Endowment, and the Society for Public Health Education. Without the advice, guidance, and partnership of these influential organizations, the REACH program would not have been as successful as it has been.

Program structure

The REACH program was initiated with funding to 40 communities. Each community was asked to focus on one or more of the following health conditions: cardiovascular disease; breast and cervical cancer; diabetes; immunizations (either child or adult); HIV/AIDS; or infant mortality. The size of the communities funded ranged from a few hundred minority residents in rural communities to populations approaching 500,000 or more in urban areas. The communities were also asked to focus on one or more of the following racial and ethnic minority groups: African-Americans; Native Americans; Alaska Natives; Hispanic-Americans; Asian-Americans; and Pacific Islanders.

The expectation with funding was for each community to create a community coalition that would develop, implement and evaluate a community action plan to address disparities in health. The coalitions were required to include one or more non-governmental agencies, a local public health agency, and an academic institution; many of the coalitions also included representatives from local hospitals and professional organizations. Each community identified the local organizations that

Figure 1
Prevalence of cholesterol screening among African-Americans in the REACH communities, African-Americans nationwide, and the US overall. Data source: the REACH Risk Factor Survey and Behavioral Risk Factor Surveillance System (in colour online)



they felt were best suited to implement activities related to the elimination of health disparities. The interventions that the communities implemented were evidence-based and tailored to the needs of the local community. CDC provided funding to each of the communities at the level of approximately US$800,000 per year. CDC also provided technical assistance to the communities through monthly conference calls, annual meetings and periodic site visits.

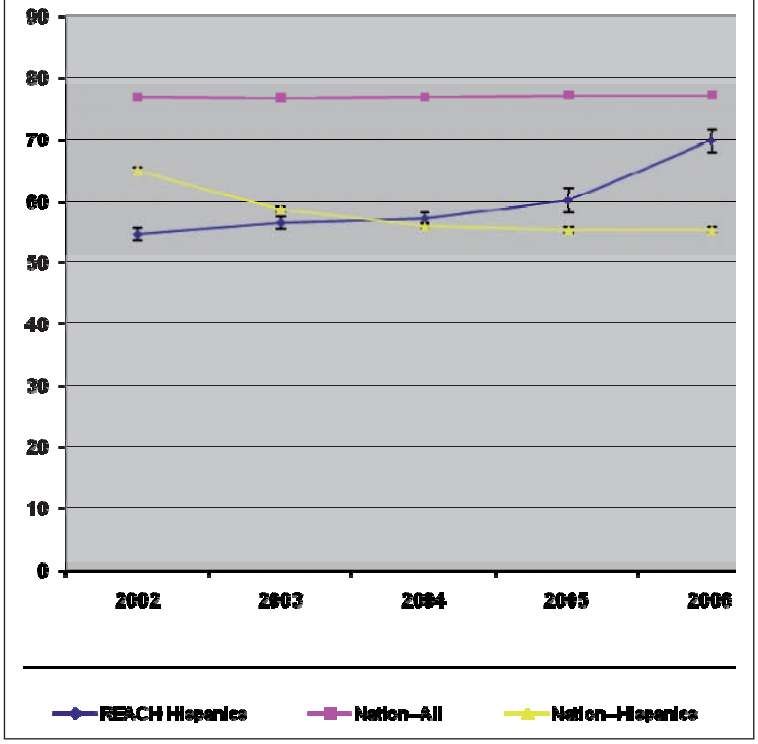
Each of the communities focused on three overriding areas. The first of these focused on providing community supports for the achievement of a healthy lifestyle. This was largely accomplished by implementing community-wide policy and environmental changes, such as creating more healthy eating options and safe places for physical activity. The second focus area involved supporting community health workers to assist in patient navigation and chronic disease management. Finally, the third focus area created activated patients by educating community members through the use of media campaigns or community health workers. These community members were educated about their chronic conditions and trained to work with their healthcare providers as active participants in the management of their diseases. As a result of these community-based efforts, we are seeing very impressive results. Additional information regarding community-specific activities may be found at www.cdc.gov/reach

Results

The REACH communities have been extremely effective in creating healthier environments for community residents.[3] In the South Central region of Los Angeles, California, where access to healthy foods is extremely limited, the community successfully advocated for a city ordinance that banned new fast-food restaurants from opening within the community. This ordinance is providing the residents with two years to develop and implement a plan to bring healthier food options to the community. In Charlotte, North Carolina, the community came together to institute a number of farmer's markets. As a result of this effort, the percentage of adults regularly consuming fresh fruits and vegetables has increased dramatically. Finally, in the Bronx neighborhood of New York City, the community was concerned about the lack of healthy food in the New York City schools. The community successfully advocated for a new school policy that allows only 1% or low-fat milk to be served in the city schools.

In addition to these community policy and environmental changes, we are also seeing dramatic improvements in the management of a number of chronic conditions.[3] In Charleston, South Carolina, where the community focused on African-Americans with diabetes, there has been a 54% reduction in lower extremity amputations among African-American men, due to improved diabetes management and control. In fact, a 21% gap in haemoglobin A1C testing that existed between African-Americans and Caucasians has been almost entirely eliminated. In Lawrence, Massachusetts, the community focused on improving diabetes management among Latino men and women. The community has achieved a 9% improvement in the

Figure 2
Prevalence of cholesterol screening among Hispanics in the REACH communities, Hispanics nationwide, and the US overall. Data source: the REACH Risk Factor Survey and the Behavioral Risk Factor Surveillance System (in colour online)



percentage of adults with a haemoglobin A1C result below 7. The community has also seen a 17% improvement in the number of hypertensive adults whose systolic blood pressure is below 140 mmHg, and a 14% improvement in the percentage of adults whose diastolic blood pressure is below 90 mmHg.

It is not just local community results that are so impressive. A look across all REACH communities shows that disparities in healthcare are being reduced or eliminated. For example, African-Americans within the REACH communities now surpass the national average in terms of the percentage of adults who have had their cholesterol checked in the last five years (Figure 1). Among Hispanics, while nationwide the percentage of adults who have had their cholesterol checked has actually decreased (Figure 2), within the REACH communities the percentage screened has increased and the disparity has been almost completely eliminated. Finally, Asian men had a 50% higher prevalence of smoking than the national average (Figure 3). Today, Asian men in REACH communities are smoking at a lower rate than their Caucasian counterparts.

REACH today

Today the REACH program supports 40 communities across the US (http://www.cdc.gov/reach). The communities focus on one or more of the following healthcare areas: cardiovascular disease; diabetes; breast and cervical cancer; asthma; immunizations; tuberculosis; and hepatitis. There are two levels of funding: Action Communities, for which there are 22 funded; and Centers of Excellence in the Elimination of Disparities (CEEDS), for which there are 18 funded.

The Action Communities are expected to develop and implement effective interventions for the elimination of health disparities. This component of funding is very similar to the design of the original REACH program.

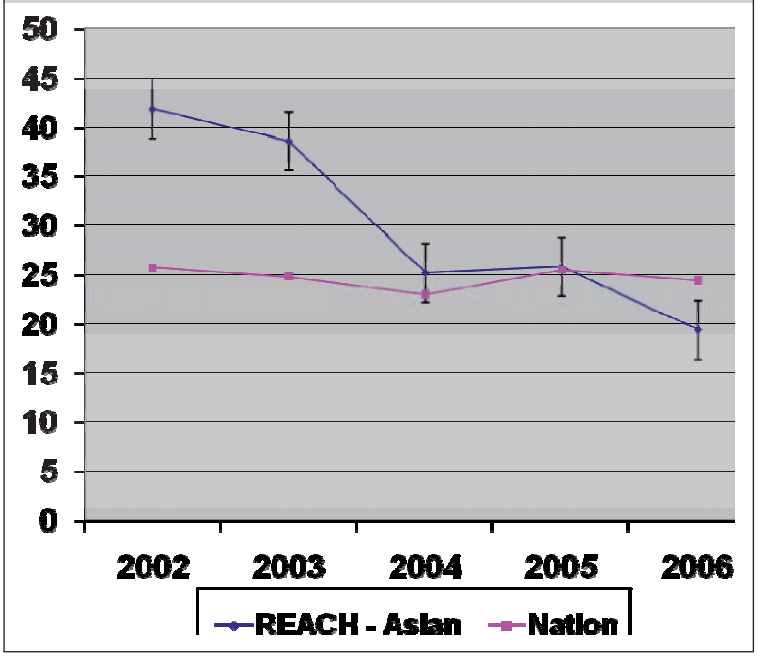
The CEEDS, in addition to designing and implementing effective interventions for the elimination of health disparities, are expected to mentor communities across the country and help them implement effective interventions to eliminate health disparities. Each CEED is expected to mentor at least six communities over the five-year funding cycle.

Concluding thoughts

The main lesson from the REACH experience is that disparities in health are not inevitable; they can be eliminated. In order for this to occur, adequate resources and technical assistance must be provided to the communities.

To successfully eliminate health disparities, it is necessary to improve health among community members and provide them with opportunities to choose a healthy lifestyle. This includes bridging the gap between the community and healthcare system, and moving beyond individual change to community and systems change. Empowering community members (through the use of media campaigns and community health workers) to seek better health and manage their chronic conditions is also necessary. Finally, it is important to implement strategies that fit the unique social, political, economic and cultural circumstances within each community.

Figure 3
Prevalence of cigarette smoking among Asian men and men overall. Data source: the REACH Risk Factor Survey and Behavioral Risk Factor Surveillance System (in colour online)



The elimination of disparities in health will not occur overnight. It will take a strong and sustained commitment, and require strong partnerships between the public health, academic and non-governmental sectors. When these partnerships thrive, the benefits to the racial and ethnic minority communities and the nation will be immense. CDC has supported a limited number of communities across the United States, but there are many more communities in need. CDC currently supports 18 Centers of Excellence that mentor communities in the elimination of health disparities, and it is anticipated that these 18 communities will mentor over 50 additional communities over the next five years. The results from the REACH program demonstrate that providing communities with adequate resources, technical assistance and mentorship can lead to the reduction and elimination of health disparities at the community level. As we look to the future, we hope that these community-wide efforts will lead to broader societal changes at the national level addressing the underlying causes of disparities, particularly the role of racism and socioecomomic disparities. It is only when nations address these widespread societal factors that we can realize WEB DuBois' vision of eliminating disparities in health.

References

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